FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037937

Facility Name: Ridgeland Center

Address: 12550 South Ridgeland Avenue (Number) Palos Heights (City) 60463 (Zip Code)

County: Cook

Telephone Number: (708) 597-9300 **Fax #** (708) 597-2472

IDPA ID Number: 22-3152450001

Date of Initial License for Current Owners: 05/01/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Laura Hillenbrand **Telephone Number:** (304) 599-0395

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Sonia Bailey-Gibson

(Title) Senior VP of Operations

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,267	8,288	6,324	30,879	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,267	8,288	6,324	30,879	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.76%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/92

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 101 and days of care provided 6,133

Medicare Intermediary Riverbend Governement Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	237,203	17,225	43,111	297,539	4,439	301,978		301,978			1
2	Food Purchase		133,216		133,216		133,216	(5,900)	127,316			2
3	Housekeeping	105,243	14,977	5,364	125,584	913	126,497		126,497			3
4	Laundry	17,938	7,678	34,634	60,250	331	60,581		60,581			4
5	Heat and Other Utilities			84,263	84,263		84,263	(1,655)	82,608			5
6	Maintenance	75,009	14,266	21,561	110,836	(540)	110,296		110,296			6
7	Other (specify):* Trash Removal			13,618	13,618		13,618		13,618			7
8	**TOTAL General Services**	435,393	187,362	202,551	825,306	5,143	830,449	(7,555)	822,894			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,914,957	145,294	(20,717)	2,039,534	17,327	2,056,861	34,710	2,091,571			10
10a	Therapy		735	371,980	372,715		372,715	(31,403)	341,312			10a
11	Activities	77,208	2,810	3,635	83,653	(1,146)	82,507		82,507			11
12	Social Services	77,944	379	4,185	82,508	581	83,089		83,089			12
13	Nurse Aide Training	21,316		2,154	23,470	(23,470)						13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,091,425	149,218	379,237	2,619,880	(6,708)	2,613,172	3,307	2,616,479			16
	C. General Administration											
17	Administrative	237,271	4,146	347,051	588,468	(564)	587,904	47,297	635,201			17
18	Directors Fees											18
19	Professional Services			2,070	2,070		2,070		2,070			19
20	Dues, Fees, Subscriptions & Promotions			6,473	6,473	1,890	8,363	(318)	8,045			20
21	Clerical & General Office Expenses		19,086	67,828	86,914		86,914	100	87,014			21
22	Employee Benefits & Payroll Taxes			537,513	537,513	(1,925)	535,588	(23)	535,565			22
23	Inservice Training & Education			614	614	1,245	1,859	(11)	1,848			23
24	Travel and Seminar			5,562	5,562	919	6,481		6,481			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,191	41,191		41,191		41,191			26
27	Other (specify):* Miscellaneous Exp			516,706	516,706		516,706	(516,613)	93			27
28	**TOTAL General Administration**	237,271	23,232	1,525,008	1,785,511	1,565	1,787,076	(469,568)	1,317,508			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,764,089	359,812	2,106,796	5,230,697		5,230,697	(473,816)	4,756,881			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Ridgeland Center #0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			49,627	49,627		49,627	118,755	168,382			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,849	3,849		3,849	174,782	178,631			32
33	Real Estate Taxes			156,292	156,292		156,292		156,292			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,761	22,761		22,761	(92)	22,669			35
36	Other (specify):*											36
37	**TOTAL Ownership**			232,529	232,529		232,529	293,445	525,974			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			205,458	205,458		205,458	(1,418)	204,040			39
40	Barber and Beauty Shops			17,215	17,215		17,215		17,215			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,147	55,147		55,147		55,147			42
43	Other (specify):* **See Attached**			38,281	38,281		38,281		38,281			43
44	**TOTAL Special Cost Centers**			316,101	316,101		316,101	(1,418)	314,683			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,764,089	359,812	2,655,426	5,779,327		5,779,327	(181,789)	5,597,538			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,480)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,355	30		9
10	Interest and Other Investment Income	(112)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(354)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,559)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(509,453)	27		24
25	Fund Raising, Advertising and Promotional	(4,601)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (458,204)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	253,365		34
35	Other- Attach Schedule	23,050		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 276,415		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (181,789)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Ridgeland Center

ID# 0037937

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PAC Dues	$ (485)	20	1
2	Estimated Legal Settlement	(9,996)	17	2
3	Add on Contract Nrsg - Overaccrual in 12/01	35,019	10	3
4	Reverse adjustment to Balance Sheet	167	20	4
5	Subtract Electric - Duplicate payment	(4,645)	5	5
6	Add on Gas - Overaccrual in 12/01	2,990	5	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	23,050		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ridgeland Center **#** 0037937 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,834)	(66)	0	0	0	0	0	0	0	0	0	(5,900)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,655)	0	0	0	0	0	0	0	0	0	0	(1,655)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,489)	(66)	0	0	0	0	0	0	0	0	0	(7,555)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	35,019	(309)	0	0	0	0	0	0	0	0	0	34,710	10
10a	Therapy	0	(31,397)	(6)	0	0	0	0	0	0	0	0	(31,403)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	35,019	(31,706)	(6)	0	0	0	0	0	0	0	0	3,307	16
	C. General Administration													
17	Administrative	(9,996)	57,293	0	0	0	0	0	0	0	0	0	47,297	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(318)	0	0	0	0	0	0	0	0	0	0	(318)	20
21	Clerical & General Office Expenses	0	100	0	0	0	0	0	0	0	0	0	100	21
22	Employee Benefits & Payroll Taxes	0	(23)	0	0	0	0	0	0	0	0	0	(23)	22
23	Inservice Training & Education	0	(11)	0	0	0	0	0	0	0	0	0	(11)	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(516,613)	0	0	0	0	0	0	0	0	0	0	(516,613)	27
28	**TOTAL General Administration**	(526,927)	57,359	0	0	0	0	0	0	0	0	0	(469,568)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(499,397)	25,587	(6)	0	0	0	0	0	0	0	0	(473,816)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ridgeland Center **#** 0037937 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	64,355	54,400	0	0	0	0	0	0	0	0	0	118,755	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(112)	174,894	0	0	0	0	0	0	0	0	0	174,782	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(92)	0	0	0	0	0	0	0	0	0	(92)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	64,243	229,202	0	0	0	0	0	0	0	0	0	293,445	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(1,418)	0	0	0	0	0	0	0	0	0	(1,418)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(1,418)	0	0	0	0	0	0	0	0	0	(1,418)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(435,154)	253,371	(6)	0	0	0	0	0	0	0	0	(181,789)	45

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Genesis Health Ventures	100	See Attached List		RLNR, Inc.	Hackensack, NJ	Property Owner
				Neighborcare	Willowbrook, IL	Pharmacy
				Genesis Rehab.	Kennett Square, PA	Therapy
				Genesis Hospitality	Kennett Square, PA	Dietary
				Genesis Staffing	Kennett Square, PA	Staffing
				Respiratory Health	Kennett Square, PA	Respiratory

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Quarterly & Annual Reports	$	RLNR, Inc.		$ 100	$ 100	1
2	V	30	Depreciation		RLNR, Inc.		54,400	54,400	2
3	V	32	Interest	3,849	Genesis Health Ventures	100.00%	178,743	174,894	3
4	V	17	Administrative	347,051	Genesis Health Ventures	100.00%	404,344	57,293	4
5	V	2	Related Party Mark-Up	66	Neighborcare			(66)	5
6	V	10	Related Party Mark-Up	289	Neighborcare			(289)	6
7	V	22	Related Party Mark-Up	23	Neighborcare			(23)	7
8	V	23	Related Party Mark-Up	11	Neighborcare			(11)	8
9	V	35	Related Party Mark-Up	51	Neighborcare			(51)	9
10	V	39	Related Party Mark-Up	1,418	Neighborcare			(1,418)	10
11	V	10a	Related Party Mark-Up	31,397	Genesis Rehab			(31,397)	11
12	V	10	Related Party Mark-Up	20	Respiratory Health			(20)	12
13	V	35	Related Party Mark-Up	41	Respiratory Health			(41)	13
14	Total			$ 384,216			$ 637,587	$ * 253,371	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	Related Party Mark-Up	$ 6	Respiratory Health		$	$ (6)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6			$ 0	$ * (6)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Facility is a publicly traded company.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Genesis Health Ventures
Street Address: 101 E. State Street
City / State / Zip Code: Kennett Square, PA 19348
Phone Number: (610) 925-4079
Fax Number: (610) 925-4853

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Costs		373	$ 140,141,312	$		$ 404,344	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 140,141,312	$		$ 404,344	25

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mellon Bank Revolving Credit		X				$ 2,698,417	$ 2,698,417		6.6300	$ 178,743	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,698,417	$ 2,698,417			$ 178,743	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,698,417	$ 2,698,417			$ 178,743	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 117,661	2
3. Under or (over) accrual (line 2 minus line 1).		$ 117,661	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,631	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 156,292	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	109,538	8
	1998	109,538	9
	1999	132,539	10
	2000	136,078	11
	2001	117,661	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ridgeland Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037937

CONTACT PERSON REGARDING THIS REPORT Laura Hillenbrand

TELEPHONE 304-599-0395 FAX #: 305-285-0624

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-30-404-033-0000	Long Term Care	$ 117,661.04	$ 117,661.04
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 117,661.04	$ 117,661.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,446 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	139,860	1992	$ 25,000	1
2					2
3	TOTALS	139,860		$ 25,000	3

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1992	1985	$ 920,000	$ 54,400	30	$ 30,667	$ (23,733)	$ 324,556	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1993	14,495		20	725	725	6,464	9
10	Leasehold Improvements			1994	8,686		20	434	434	7,202	10
11	Leasehold Improvements			1995	28		20	1	1	9	11
12	Leasehold Improvements			1996	54,659		20	2,733	2,733	17,967	12
13	Leasehold Improvements			1997	115,504		20	5,769	5,769	32,111	13
14	Leasehold Improvements			1997	2,891,042		35	82,601	82,601	419,888	14
15	Leasehold Improvements			1998	143,810		35	2,380	2,380	11,900	15
16	Flooring			2000	799		35	23	23	69	16
17	Install Fire sprinkler system			2000	71,848		35	2,053	2,053	6,159	17
18	Punch key locks			2000	1,190		35	34	34	102	18
19	Sprinkler system			2000	59,520		20	2,976	2,976	8,928	19
20	Sprinkler system			2001	23,100		35	660	660	1,320	20
21	Wheelchair ramp			2001	2,700		35	77	77	154	21
22	Sidewalk			2001	4,003	200	20	200		400	22
23	Fire Smoke Damper			2002	2,995		20	137	137	137	23
24	Push Button Locks			2002	778	59	7	65	6	65	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,315,157	$ 54,659		$ 131,535	$ 76,876	$ 837,431	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 242,770	$ 46,017	$ 33,496	$ (12,521)	5-7	$ 174,106	71
72	Current Year Purchases	44,600	3,352	3,352		5-7	3,352	72
73	Fully Depreciated Assets	642,299					642,299	73
74								74
75	TOTALS	$ 929,669	$ 49,369	$ 36,848	$ (12,521)		$ 819,757	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,269,826	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,028	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,383	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 64,355	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,657,188	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 22,356 Description: Admin $3144, Ancillary $5354, Dietary $1679, Nrsg $12,179
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	99 Plymouth Voyager	$ 409.00	$ 405	17
18					18
19					19
20					20
21	TOTAL		$ 409.00	$ 405	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 2&3	hrs	$	3,278	$ 189,331	$ 464	3,278	$ 189,795	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		350	19,445		350	19,445	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2&3	hrs		2,670	162,351	272	2,670	162,623	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				199,754		199,754	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RT	10a, 3			18	853		18	853	13
14	TOTAL			$	6,316	$ 371,980	$ 200,490	6,316	$ 572,470	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 38,133	$ 38,133	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	576,173	576,173	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,749	9,749	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 624,055	$ 624,055	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	12,964	436,962	13
14	Buildings, at Historical Cost	2,995	1,816,308	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	271,908	271,908	16
17	Accumulated Depreciation (book methods)	(66,652)	(139,185)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 221,215	$ 2,385,993	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 845,270	$ 3,010,048	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 219,872	$ 219,872	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	203,853	203,853	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	205,078	153,336	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Liabilities	22,033	22,033	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 650,836	$ 599,094	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Due to Related Party	573,960	2,900,781	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 573,960	$ 2,900,781	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,224,796	$ 3,499,875	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (379,526)	$ (489,827)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 845,270	$ 3,010,048	48

***(See instructions.)**

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,737,659	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,737,659	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(444,726)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **Fresh Start - Bankruptcy Entry**	(1,703,942)	15	
16	Other (describe) **Depreciation Adjustment**	31,482	16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,117,186)	17	
	B. Transfers (Itemize):			
18	**Rounding**	1	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (379,526)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,164,184	1
2	Discounts and Allowances for all Levels	(1,259,358)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,904,826	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	686,704	6
7	Oxygen	12,788	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 699,492	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,776	13
14	Non-Patient Meals	5,480	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	241,675	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,334	19
20	Radiology and X-Ray	25,443	20
21	Other Medical Services	384,380	21
22	Laundry	15,816	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 727,904	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	112	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 112	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	2,267	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,267	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,334,601	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	825,306	31
32	Health Care	2,619,880	32
33	General Administration	1,785,511	33
	B. Capital Expense		
34	Ownership	232,529	34
	C. Ancillary Expense		
35	Special Cost Centers	260,954	35
36	Provider Participation Fee	55,147	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,779,327	40
41	**Income before Income Taxes (line 30 minus line 40)****	(444,726)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (444,726)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,019	2,192	$ 65,039	$ 29.67	1
2	Assistant Director of Nursing	1,486	1,655	40,278	24.34	2
3	Registered Nurses	14,178	15,330	387,910	25.30	3
4	Licensed Practical Nurses	23,681	26,158	558,478	21.35	4
5	Nurse Aides & Orderlies	67,124	73,439	837,337	11.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,247	6,751	76,128	11.28	10
11	Social Service Workers	4,569	4,995	78,524	15.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,579	20,217	241,641	11.95	15
16	Dishwashers					16
17	Maintenance Workers	4,408	4,683	74,468	15.90	17
18	Housekeepers	11,298	12,722	106,156	8.34	18
19	Laundry	2,294	2,531	18,269	7.22	19
20	Administrator	1,886	2,098	76,272	36.35	20
21	Assistant Administrator					21
22	Other Administrative	10,390	11,284	160,434	14.22	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,516	3,987	43,155	10.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,675	188,042	$ 2,764,089 *	$ 14.70	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	18,000	9, 3	36
37	Medical Records Consultant		4,185	12, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed charge	5,908	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,093		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
See Attached Sheet			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Steptoe & Johnson PLLC	Legal Fees	$ 1,575
Sheriff of Cook County	Levy Payment	495
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,070

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,075
Unemployment Compensation Insurance	25,197
FICA Taxes	203,780
Employee Health Insurance	168,659
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	14,723
Recruiting Fees	17,618
Retirement Plan	4,513
TOTAL (agree to Schedule V, line 22, col.8)	$ 535,565

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,890
(Indicate # of checks performed)	
IL Health Care Assoc Dues	4,805
CLIA User Fee	150
IDPA Approval Fee	1,000
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,045

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,520
Seminar Expense	961
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,481

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Ridgeland Center # 0037937 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Ridgeland Center **#** 0037937 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL Health Care Assoc $4805**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,130** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,147**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **5,480**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG Peat Marwick** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Not Yet Available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

RIDGELAND CENTER
MEDICAID #: 22-3152450001
COST REPORT PERIOD: JAN 1, 2002 - DEC 31, 2002
SPECIAL COST CENTERS - PAGE 4

	REFER.	COST
Laboratory Fees	V4.4303	11,665
X-Ray Expense	V4.4303	26,616
		38,281

RIDGELAND CENTER
MEDICAID #: 22-3152450001
COST REPORT PERIOD: JAN 1, 2002 - DEC 31, 2002
MISCELLANEOUS REVENUE

Description	Amount
Prior Period Patient Revenue	1,970.72
Garnishment Revenue	54.00
Copy Revenue	222.75
Uniform Reimbursement	20.00
	2,267.47

RIDGELAND CENTER
MEDICAID #: 22-3152450001
COST REPORT PERIOD: JAN 1, 2002 - DEC 31, 2002
ADMINISTRATOR SALARY

Name	Title	Ownership %	Amount
Scott Lehnert	Administrator	0.00%	76,272
Paula Stanislaw	Office Manager	0.00%	47,394
Amanda Lona	A/R Assistant	0.00%	28,190
Joyce Thomas	Bookkeeper	0.00%	30,136
Lori Bailey	Bookkeeper	0.00%	1,963
Shannon Schwartz	FT Receptionist	0.00%	25,863
Germaine Salmon	PT Receptionist	0.00%	9,483
Jennifer Niemeic	PT Receptionist	0.00%	7,759
Reclassed Out	Admissions Director	0.00%	215
(Non-Allowable)	Legal Settlement	0.00%	9,996
			237,271